



# Blood Request Form

A Gold Standard

Leslie Delieu



# Our form

- Please retrieve the copy from your pack –

It looks like this:-

**PRESS FIRMLY ON EACH END TO ENSURE A  
LEAKPROOF SPECIMEN CARRIER**

1833333

[illegible]

PLACE SPECIMEN IN BAG. REMOVE COVERING STRIP. FOLD OVER TO SEAL.

**TAPE TO SEAL BAG**

## HOSPITAL BLOOD TRANSFUSION REQUEST FORM

It is a mandatory requirement that all staff who undertake pre-transfusion sampling have been certified competent in accordance with National Patient Safety Agency Notice 14, Right Patient, Right Blood (2006).

Request and Sample Date – Minimum Acceptance Criteria

- The blood sample should be taken into a 6ml EDTA Blood Transfusion bottle.
- Positive Patient Identification: the sample tube must be labelled beside the patient and hand written with the patient's full name, DOB and NHS/Hospital number.
- The form must be signed, dated and timed by the person taking blood.
- An addressograph label is acceptable on the request form providing the Ward/Consultant and Date/Time taken is recorded.
- An addressograph label is acceptable on the sample if vein to vein traceability system only.
- All relevant sections of the request form MUST be filled in and signed as appropriate or the samples will be REJECTED.
- Special Requirements: RESPONSIBILITY OF THE CLINICIAN TO REQUEST: Is this patient (or has ever been referred as) a patient with a malignant haematology or oncology diagnosis please check whether they have any special transfusion requirements.
- The sample will be held for up to seven days. If the patient has been transfused more than 72 hours previously, a new sample is required according to the local guidelines.

Sample Times:

Patient transfused or pregnant within	Sample to be taken
< 3 months:	72 hours before retransfusion
> 3 months:	7 days before retransfusion

### BEDSIDE LABELLING CRITERIA



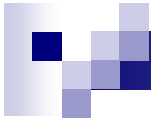
**CHECK IT!!!**

- Forename
- Surname
- DOB
- Hospital/NHS Number
- Date & Initial/Sign



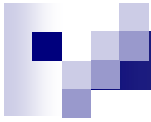
### FAILURE TO CORRECTLY IDENTIFY PATIENTS COULD BE FATAL

Version 13072013 B



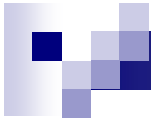
# Things to think about

- Why do it?
- How to do it?
- Who to involve?
- What impact will change have?
- Where to present it?
- What evidence backs it up?
- Where can you share it?



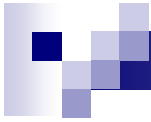
# Drawing a blank.....

- Have you ever looked at a form and known it could be better but not sure where to start?
- Have you ever wanted to change something but thought the obstacles would be insurmountable?
- Us too!!



# Why change?

- Many hospitals have used the same form for years-
- Often they do not reflect current guidance  
BCSH, HSC, NPSA, RCN, SABTO, SHOT etc.
- Merging Services.
- Movement of healthcare workers.



# A meeting of minds

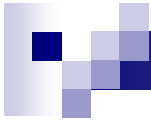
- Worthing – The primary mover, tentatively presented an idea for a new request form to the TADG.
- TADG – Should we have a regional form?
- Suggestion taken to RTC.



# Support from RTC

- RTC assigned the task to RTT.
- RTT – MR lead, LD, AG.
  - look at examples from our hospitals
  - look at examples from Wales and Northern Ireland
- MR put together a form reflecting current practices.
- MR, LD, AG made changes and agreed upon a draft Blood Request Form to present to the SEC RTC.






# Starting a project

- Creativity is great but plagiarism is faster!!, but make sure you give credit where it's due!
- Sharing practice is invaluable.
  - Looking at other forms is a good way of making sure you don't forget anything.
  - Deciding what to exclude can be as valuable as deciding what to include.



# Editing

- No form stays at draft 1!!
- Ask for feedback
  - limit the audience; be specific.
  - Have representation from the staff groups who will use the form.
- Set a rigid cut off date.
- Expect criticism and take it on-board



## Ask for feedback early in the process

- This was presented at the next TADG and feedback requested.
- Amendments were made and the final version presented to the wider RTC.
- Presentation at HTCs was encouraged.
- Feedback was received and acted upon.
- Final version approved -



# Evidence

- British Committee for Standards in Haematology (BCSH) Guidelines on the Administration of Blood Components, 2009
- **Right blood, right patient, right time** *RCN guidance for improving transfusion practice 2005 Royal college of nursing.*
- National Patient Safety Agency (NPSA)
  - Safer PRACTICE notice 14 Right Patient Right Blood (2006)
  - Update on “Right Patient Right Blood
  - competency assessment” (2008)
- DoH Health Service Circular HSC – [doh.gov.uk/publications](http://doh.gov.uk/publications)
  - 2002/009 Better Blood Transfusion 2 – appropriate use of blood
  - 2007/001 Better Blood Transfusion 3 – safe and appropriate use of blood
- Serious Hazards of Transfusion website: [www.shot-uk.org](http://www.shot-uk.org)
  - Annual reports and recommendations
- Patient consent for blood transfusion - Advisory Committee on the Safety of Blood Tissues and Organs (SaBTO) 21 Oct 2011 - DoH website



# Implementation

- Take to HTC for discussion
- Use when reviewing and renewing own forms
- Trust ratification processes
- Change control documentation
- Education



# Accessing this form electronically

- From mid - February 2013  
down load a non pdf format from the SEC  
RTC webpage.
  - ☐ Use as it is
  - ☐ Make your own changes
- [http://www.transfusionguidelines.org/index.asp?  
Publication=RTC&Section=28&pageid=1249](http://www.transfusionguidelines.org/index.asp?Publication=RTC&Section=28&pageid=1249)



# Over to you

- Your experiences of sharing and using this form, in whole or part are very valuable to us and feedback can be directed via the RTC secretary Emma Whitmore

□ [Emma.whitmore@nhsbt.nhs.uk](mailto:Emma.whitmore@nhsbt.nhs.uk)



# That's all folks!!

- Thank you
- Special thanks for the slides to
  - Emma Whitmore & Malcolm Robinson